



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEMORIAL HERMANN HOSPITAL SYSTEM

Respondent Name

WAUSAU BUSINESS INSURANCE

MFDR Tracking Number

M4-06-3572-02

Carrier's Austin Representative

Box Number 01

MFDR Date Received

JANUARY 23, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier issued payments in the total amount of \$55,887.27...Because the hospital's usual and customary charges exceed the stop loss threshold, payment should have been made at 75% of total charges...After providing an offset for past payments, Requestor is entitled to additional payment of \$12,923.07, plus interest."

Amount in Dispute: \$12,923.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 4, 2006: "We have received the medical dispute filed by Memorial Hermann Fort Bend Hospital for services rendered to [Claimant] between the dates of service 1/24/05-1/28/05. The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same...Liberty Mutual does not believe that Memorial Hermann Fort Bend Hospital is due any further reimbursement."

Response Submitted by: Liberty Mutual Insurance

Respondent's Supplemental Position Summary Dated August 1, 2014: "Because Requestor has not met its burden of demonstrating the existence of both unusually extensive *and* unusually costly services, and the documentation adduced thus far fails to provide any rationale which might justify the Requestor's qualification for payment under the Stop-Loss Exception, Respondent's payment was appropriate. No additional monies are due to the Requestor."

Responses Submitted by: Hanna & Plaut L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2005 through January 28, 2005	Inpatient Hospital Services	\$12,923.07	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - F-Reduction according to fee guidelines.
 - M-Reduced to fair and reasonable.
 - Z585-The charge for this procedure exceeds fair and reasonable.
 - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
 - Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
 - Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.
 - X322-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
6. Dispute M4-06-3572 History
 - Dispute was originally decided on May 19, 2006.
 - The original dispute decision was appealed to District Court.
 - District Court remanded the dispute to the Division pursuant to an agreed order of remand, cause number D-1-GN-06-002151, dated January 30, 2012.
 - Because of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
 - M4-06-3572-02 is hereby reviewed

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed \$40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28

Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$91,747.25. The Division concludes that the total audited charges exceed \$40,000.
2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services" and further states that "...independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor states that "Because the hospital's usual and customary charges exceed the stop loss threshold, payment should have been made at 75% of total charges." This position does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor does not demonstrate how the services in dispute were unusually extensive compared to similar spinal surgery services or admissions. The requestor presumes that the disputed services meet Stop-Loss because the hospital's usual and customary charges exceed the stop loss threshold, thereby presuming that the admission was unusually extensive. This presumption is not supported in the documentation submitted. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
3. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. Neither the requestor's position statements, nor the documentation provided demonstrate how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was four days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of four days results in an allowable amount of \$4,472.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
 - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$55,439.00.
 - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Perioperative Implant Record	QTY.	Cost Per Unit	Cost + 10%
Expedion Screw 35mm	2	\$1,285.00	\$2,827.00
Expedion Screw 40mm	6	\$1,208.00	\$7,972.80
Prebent Rod 65mm	1	\$293.25	\$322.58

Prebent Rod 75mm	1	\$293.25	\$322.58
Prebent Rod 85mm	1	\$293.25	\$322.58
Prebent Rod 95mm	1	\$293.25	\$322.58
Set Screw	8	\$190.00	\$1,672.00
Leopard Cage 11mm	1	\$3,782.50	\$4,160.75
Leopard Cage 12mm	1	\$3,782.50	\$4,160.75
Leopard Cage 15mm	1	\$3,782.50	\$4,160.75
Conduit TCP 10cc	1	\$1,432.10	\$1,575.31
TOTAL			\$27,819.66

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that “When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399).” A review of the submitted hospital bill finds that the requestor billed \$768.00 for revenue code 390-Blood/Storage Processing. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

The division concludes that the total allowable for this admission is \$32,291.66. The respondent issued payment in the amount of \$55,887.37. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

09/22/2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.